

FILED DEC 4 1948

THE STATE BOARD OF HEALTH OF MISSOURI  
STANDARD CERTIFICATE OF DEATH

State File No. 36466  
4539

Registration District No. 249

Primary Registration District No. 1002

Registrar's No.

1. PLACE OF DEATH:

(a) County Jackson  
(b) City or town Kansas City  
(If outside city or town limits, write "RURAL" and name of township)  
(c) Name of hospital or institution: 5724 Wyandotte  
(If not in hospital or institution, write street number or location)  
(d) Length of stay: In hospital or institution XX (Specify whether)  
In this community Life (Specify whether)  
years, months or days

3. (a) PRINT FULL NAME JOHN MIKEL CRAHAN

3. (b) If veteran, No name war No  
3. (c) Social Security No. 709-16-4261

4. Sex Ma 5. Color or race Wh  
6. (a) Single, widowed, married, divorced Married  
6. (b) Name of husband or wife Margaret Crahan  
6. (c) Age of husband or wife if alive 62 years  
7. Birth date of deceased October 18 1884  
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day  
64 0 17 hr. min.

9. Birthplace Kansas City (City, town, or county) Mo. Kansas (State or foreign country)

10. Usual occupation City Freight Agent

11. Industry or business Sante Fe R.R.

12. Name James Crahan

13. Birthplace Illinois (City, town, or county) (State or foreign country)

14. Maiden name Mary Garvey

15. Birthplace Richmond (City, town, or county) Virginia (State or foreign country)

16. (a) Informant Mrs. Margaret Crahan

(b) Address 5724 Wyandotte

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 11-9-48 (Month) (Day) (Year)

(c) Place: burial or cremation Calvary

18. (a) Signature of funeral director J. Wagner

(b) Address Kansas City, Mo.

19. (a) 11-8-48 (Date received local registrar) (b) Heraldine Holmes (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Jackson  
(c) City or town Kansas City  
(If outside city or town limits, write "RURAL")  
(d) Street No. 5724 Wyandotte  
(If rural, give location)  
(e) Citizen of foreign country? No (Yes or No)  
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Nov. day 5th  
year 1948 hour 11:00 minute P M.

21. I hereby certify that I attended the deceased from 1-10-48, 19  , to 11-5-48, 19  ;  
that I last saw him alive on 11-5-48, 19  ;  
and that death occurred on the date and hour stated above.

Immediate cause of death Carcinoma lung

Due to

Due to

Other conditions: 478  
(Include pregnancy within 3 months of death)

Major findings:  
Of operations

Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:—

(a) Accident, suicide, or homicide (specify) \_\_\_\_\_  
(b) Date of occurrence \_\_\_\_\_  
(c) Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)  
(d) Did injury occur in or about home, on farm, in industrial place, in public place? \_\_\_\_\_

While at work? \_\_\_\_\_ (Specify type of place)  
(c) Means of injury Graham Owens  
23. Signature Graham Owens (M. D.)  
Address 8906 Grand PC Mo Date signed 11-8-48

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....  
working under my personal supervision.

Signed Alvin R. Haunschild

Licensed Embalmer No. 4159

P. O. Address Kansas City Mo

**Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)**

**If this body is not embalmed, fact should be so stated above.**